BONNEY LAKE
Physical Therapy & Hand Rehab, PLLC

Brief Medical History

Please Print Clearly

Patient Name:_______________________________Birthdate:___________Date of Inury/Onset/Surgery:_________

Street Address:____________________________________City, State, Zip:______________________________

Cell Number:____________________Home Number:______________________Work Number:________________

E-mail address:___________________________________Sex: F / M Marital Status: M__ S__ W__ D__ O__

Guardian/Power of Attorney Name & Phone______________________________________Relation:____________

Emergency Contact Name & Phone: ___________________________________

Hand Dominance: Right / Left Height:_____Weight:______

Employed: (circle one) Full Time Part Time Retired Disabled Student Homemaker Unemployed

If employed; Title & Duties:____

What activities do you have difficulty doing due to your injury / condition? __________________________

____

Previous treatment(s) for injury: Y / N (If yes, please explain)_____________________________________

Goals for Therapy:____

Pain level scale "0-10": 0 = no pain / 10 = hospital trip: Resting: ________ Activity: ________ Sleeping: ________

How many falls have you had in the past 12 months?_____ If Yes, Injuries due to fall?_________________

Please indicate any conditions you have now or in the past:

Diabetes	Yes / No	Do you smoke?	Yes / No
High Blood Pressure	Yes / No	Sensitivity Ice / Heat	Yes / No
Heart Disease / Attack	Yes / No	Orthopedic injuries/concerns (back/neck)	Yes / No
Pacemaker	Yes / No	Orthopedic injuries/concerns (extremities)	Yes / No
TMJ Disorders	Yes / No	Orthopedic Implants or Artificial Joints	Yes / No
Headaches	Yes / No	Previous Surgery	Yes / No
Kidney Disorders	Yes / No	Hernia	Yes / No
Nervous Disorders	Yes / No	Pregnant	Yes / No
Circulatory Disorders	Yes / No	Cancer: Type ____________________	Yes / No
Pulmonary Disorders	Yes / No	Dizziness, Blurred Vision, Seizures	Yes / No
Asthma	Yes / No	Previous Vehicle Accident	Yes / No
Depression / Emotional	Yes / No	Forgetfulness	Yes / No
CVA / Stroke	Yes / No	Arthritis	Yes / No
Head Injury	Yes / No	Other Illness	Yes / No

If yes on any of the above, please explain and give approximate dates. ____________________________

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Allergies: ____

Do you have sensitivity to latex? Yes _______ No _______

Current medications: Yes / No If yes, please list and for which condition: ___________________________

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The undersigned acknowledges and agrees that the above information is true and correct.

______________________________________ ______________________________

Signature Date

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